IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, *et al.*

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF TREASURY, *et al*.,

Defendants.

Civil Action No. 18-2133

PLAINTIFFS' MEMORANDUM OF LAW IN SUPPORT OF THEIR MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

In this case, federal agencies (the Departments[1]) issued a rule that has the express purpose of undermining a law enacted by Congress. In doing so, the agencies distorted the plain statutory language; ignored the expressly stated congressional goals; discarded, without meaningful explanation, the position taken just two years ago by these same agencies on the identical question; and disregarded, without any legitimate justification, hundreds of comments objecting to the change in agency policy. And the Departments did all that for a rule that will have significant and destructive effects, causing immediate disruption in the Nation's health insurance market and leaving many individuals with inadequate—or no—health insurance.

In the Patient Protection and Affordable Care Act (ACA), 124 Stat. 119, Congress sought to expand health insurance coverage, bolster health insurance markets, and ensure that health insurance policies offer real protection to policyholders. To do so, Congress put in place a specific health insurance model. The ACA thus mandates that virtually all policies sold on the individual market—where individuals purchase insurance for themselves and their families (as opposed to employer-provided insurance)—comply with "guaranteed issue" and "community rating" requirements, which respectively (1) bar insurers from denying coverage to any person because of his or her preexisting conditions or health history and (2) preclude insurers from charging higher premiums based on health history, gender, and (with some limits) age. The ACA also requires that health insurance policies offer a set of "essential" benefits to covered individuals, ensuring that health insurance is meaningfully protective.

[1] These are the Departments of the Treasury, Health and Human Services, and Labor.

The ACA exempts from these requirements "short-term, limited duration insurance" (STLDI), a narrow exception intended (as the language suggests) to permit the sale of temporary policies to people who are between annual insurance plans.

In the regulation challenged here (the STLDI Rule or Rule), however, the Departments determined that a "short-term, limited duration" plan may last for ***any period short of a year*** and may be extended up to ***36 months***. They did so with the express goal of creating an alternative health insurance market that effectively excludes people with pre-existing conditions. By drawing healthier people out of ACA-compliant plans, the Rule also will increase the costs and undermine the stability of the market established by the ACA. And it will produce a system in which many people end up with insurance that is wholly inadequate for their needs. That is why the entities most knowledgeable about the Nation's health care system—among them the leading associations of physicians (including the American Medical Association), of patient associations (including the American Cancer Society), and of health care consumers (including the AARP)—have appeared here as *amici* to forcefully contest the Rule's validity.

This Rule is indefensible as a matter of law: "Disagreeing with Congress's expressly codified policy choices isn't a luxury administrative agencies enjoy." *Central United Life Ins. Co. v. Burwell*, 827 F.3d 70, 73 (D.C. Cir. 2016). This Court should hold the Rule invalid.

STATEMENT OF FACTS[2]

1. Regulation of individual health insurance coverage under HIPAA. In 1996, Congress enacted the Health Insurance Affordability and Accountability Act (HIPAA), Public Law 104-191, 110 Stat. 1936, an insurance reform statute that, among other things, established limited

[2] Because review here is premised on the administrative record, this motion is not accompanied by a statement of undisputed material facts, but instead includes a statement of facts that cites to the administrative record. *See* D.C. LCvR 7(h)(2).

federal standards for "individual health insurance coverage" and mandated that such coverage provide for guaranteed plan renewability. Under this requirement, an insurer must offer continued insurance to a currently insured individual whose plan is expiring, even if that individual utilized the insurance or suffered adverse health consequences during the plan term. *Id.* § 111, 110 Stat. 1979, 1982. But Congress in HIPAA exempted STLDI plans from that requirement (*see id.* § 102, 110 Stat. 1973 (codified at 42 U.S.C. § 300gg-91)); such plans were placed outside HIPAA because they "traditionally [had been] sold to consumers who are trying to fill coverage gaps for a few months."[3] The Departments then had to define what constituted an STLDI plan for HIPAA purposes.

Accordingly, the Departments adopted an interim final rule in 1997 that defined "short-term limited duration coverage" to mean "health insurance coverage provided under a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within 12 months of the date the contract becomes effective."[4] The final rule adopted in 2004 contained the same language.[5]

As several commenters noted during the 2018 rulemaking challenged here, the Departments' decision in 1997 to interpret "short term" as permitting a 364-day contract was

[3] Anna W. Mathews, *Sales of Sort-Term Health Policies Surge*, The Wall Street Journal (Apr. 10, 2016), available at http://www.wsj.com/articles/sales-of-short-term-health-policies-surge-1460328539, cited at 81 Fed. Reg. 75316, 75318 n.16 (Oct. 31, 2016).

[4] *Interim Rules for Health Insurance Portability for Group Health Plans*, 62 Fed. Reg. 16,894, 16,958 (Apr. 8, 1997).

[5] *Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers Under HIPAA Titles I & IV*, 69 Fed. Reg. 78,720 (Dec. 30, 2004).

likely arbitrary and capricious.[6] Indeed, nothing in the 1997 preamble to the interim final rule defended this element of the Departments' definition, suggesting that the Departments did not give close consideration to this provision, and ***no*** comments addressed this aspect of the 1997 rule. But because HIPAA did not impose substantial requirements on the content of individual or group insurance plans, the federal classification of a plan as STLDI—rather than as continuing or long-term insurance—made no significant practical difference. Accordingly, this aspect of the Departments' definition went unchallenged.

2. Congress's enactment of the ACA to address discrimination in and promote accessibility to health insurance. During this period, and prior to the enactment of the ACA, many individuals faced substantial discrimination in (or were effectively priced out of) the insurance market.[7] In most states, insurance companies could discriminate in premiums or coverage against individuals based on pre-existing conditions, claims history, health status, age, gender, occupation, and other factors. That risk segmentation both made health insurance unavailable to many Americans as a practical matter (because individuals with the risk of higher health costs faced unaffordable health insurance premiums) and led to wide and unsustainable fluctuations in costs for individuals.[8]

Congress responded to these problems by enacting the ACA, which it intended "to increase the number of Americans covered by health insurance and decrease the cost of health care." *National Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012) ("*NFIB*"). Insofar as is relevant here, the ACA had two central goals:

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[6] *See, e.g.*, Comment of Timothy Stoltzfus Jost, Apr. 20, 2018, p.4-5, https://www.regulations.gov/document?D=CMS-2018-0015-8143.

[7] H.R. Rep. No. 111-299, tit. 3, pt. 1.

[8] *See, e.g.*, Cong. Research Serv., *Private Health Insurance Provisions in Senate-Passed H.R. 3590, The Patient Protection and Affordable Care Act* 5 (Jan. 29, 2010).

First, the ACA "adopt[ed] a series of interlocking reforms designed to expand coverage in the individual health insurance market." *King v. Burwell*, 135 S. Ct. 2480, 2585 (2015). To this end, it established a "guaranteed issue" requirement, mandating that each insurer offering coverage in the individual and group markets in a State "accept every employer and individual in the State that applies for such coverage," thus prohibiting the prior practice of refusing coverage to individuals with a history of health problems or a chronic disease condition.[9] An insurer in the individual or group market therefore may not limit or deny coverage based on the covered parties' pre-existing conditions.[10]

The ACA also includes a "community rating" provision that limits premium discrimination in the individual and small group health insurance markets. This provision forbids variations in premiums except those based on enumerated factors, while limiting the rate variation permitted under those factors.[11] Thus, tobacco use is a permissible factor, "except that such rate shall not vary by more than 1.5 to 1"; so is age, "except that such rate shall not vary by more than 3 to 1 for adults"; and geography may be considered only in the context of rating areas established by the State.[12] Factors such as health status, claims history, race, gender, sexual orientation, geography (except for rating areas established by the State), occupation, and many others may not be considered by insurers in setting rates.[13] These provisions ensure that discriminatory pricing practices no longer unduly affect certain purchasers in the individual insurance market, as had been commonplace prior to the ACA's enactment.

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[9] 42 U.S.C. § 300gg-1(a).

[10] *Id.* § 300gg-3.

[11] *Id*. § 300gg.

[12] *Id.*

[13] *See id.*

Congress regarded guaranteed issue and community rating as essential to the operation of well-functioning insurance markets. These requirements make all enrollees in the individual market "members of a single risk pool"[14]; this pooling in turn satisfies the ACA's core mission of making insurance affordable for all by spreading risk across all enrollees, ensuring that risk pools include both the healthy and the sick. To further expand the number of persons in this risk pool, Congress (1) provided refundable tax credits to assist the purchase of insurance by individuals with defined household incomes and (2) required that individuals who did not have qualified health insurance must pay a tax penalty. *See King*, 135 S. Ct. at 2487.

This guarantee of coverage carried with it the risk of adverse selection—that individuals would wait to purchase insurance until they needed health care, which would produce a risk pool skewed toward individuals with high medical costs and therefore increase insurance premiums. Congress enacted several measures to guard against that possibility. In particular, the ACA instructs the Secretary of HHS to provide open enrollment periods for purchasing ACA-compliant plans, so as to encourage individuals to sign up for insurance at the beginning of the year rather than wait to do so until a medical condition arises. 42 U.S.C. § 18031(c)(6)(B). Congress also recognized that some people might miss the open enrollment period through no fault of their own, and accordingly instructed the Secretary to provide for special enrollment periods to ensure that the Act's promise of guaranteed coverage remains available for these individuals. *Id.* § 18031(c)(6)(C). The Secretary responded by providing a special enrollment period for persons who lose minimum essential coverage mid-year. 45 C.F.R. § 155.420(d)(1).

Second, the ACA established minimum substantive standards to eliminate abuses and ensure that policies purchased in the individual insurance market will in fact provide meaningful

[14] *Id*. § 18032(c).

coverage. Congress thus required that all individual and small group plans provide a "comprehensive" package of "essential health benefits." 42 U.S.C. § 300gg-6(a). This package includes ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health services, substance use services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care). 42 U.S.C. § 300gg-6(a). The ACA also extended mental health parity to the individual insurance market, ensuring coverage of mental health and substance use disorder treatment comparable to that for physical health care. In addition, the ACA bans lifetime and annual dollar limits on insurance benefits, and includes other financial protections for enrollees, such as limitations on cost-sharing requirements.[15]

3. The Departments' amendment of their STLDI regulation to harmonize it with the ACA. In enacting the ACA's reforms, Congress had to specify the category of insurance plans to which the new requirements applied. It did so by cross-referencing HIPAA's definition of "individual health insurance coverage" and defining plans that complied with the ACA's requirements as "qualified health plans."[16]

After the ACA's enactment, the Departments realized that they would need to revisit their prior rulemakings under HIPAA to reconcile their implementation of that statute with the ACA's comprehensive reforms of the insurance market. This effort included a reconsideration of the 1997 definition of "short-term, limited-duration," which certain insurers had begun using in novel ways to circumvent the ACA's requirements.

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[15] See 42 U.S.C. § 18022(a), (c) (limitations on cost-sharing); *id*. § 18022(d) (minimum actuarial value).

[16] Qualified health plans must comply with additional requirements as well; we use that term here for convenience.

STLDI plans, which traditionally were used for transitional coverage, are exempt from the HIPAA requirement that insurance plans be guaranteed renewable; an STLDI provider may decline to continue covering an insured individual when the insurance term ends. In addition, and of particular significance here, because STLDI plans fall outside the definition of "individual health insurance coverage" used in the ACA, they are not subject to the ACA provisions that prohibit insurers from refusing coverage based on an individual's pre-existing health conditions and from setting premiums based on an individual's health history, gender, or (outside specified parameters) age. STLDI plans likewise may omit essential health benefits that must be provided by ACA-compliant individual health insurance plans, and need not adhere to the ACA's limits on patients' out-of-pocket expenses. Thus, STLDI plans may omit essential health benefits and engage in other business practices that are forbidden to ACA-compliant individual health insurance plans. Use of STLDI plans as a primary form of insurance therefore would frustrate the express purposes of the ACA.

The Departments began considering this issue in 2014, the first year for which ACA-compliant plans were available, after it became apparent that some insurers would use STLDI plans to circumvent the ACA reforms. *See* 81 Fed. Reg. 75316, 75318 & n.16 (Oct. 31, 2016) (citing Anna W. Mathews, *Sales of Sort-Term Health Policies Surge*, The Wall Street Journal (Apr. 10, 2016), available at http://www.wsj.com/articles/sales-of-short-term-health-policies-surge-1460328539). That process culminated in a 2016 final regulation, in which the Departments concluded that, to qualify as an STLDI plan, "coverage must be less than three months in duration, including any period for which the policy may be renewed."[17]

[17] 81 Fed. Reg. at 75,318.

The Departments provided detailed, reasoned explanations for this definition in the 2016 rulemaking. They explained that STLDI plans historically had been "designed to fill temporary gaps in coverage when an individual is transitioning from one plan or coverage to another plan or coverage."[18] But, the Departments continued, such plans now were being purchased by some individuals "as their primary form of health coverage," even though these plans did not provide "the protections of the Affordable Care Act" and thus "may not provide meaningful health coverage."[19] Moreover, the pricing of STLDI plans based on the insured's health history would allow these plans to target "healthier individuals," thereby "adversely impacting the risk pool for Affordable Care Act-compliant coverage."[20] Accordingly, the Departments determined that a tailored definition of STLDI was necessary to "improve the Affordable Care Act's single risk pool" and keep premiums for all participants in the individual health market at an affordable level.[21]

4. Congress's continued support for the ACA and promulgation of the STLDI Rule. Congress has repeatedly considered, and rejected, proposals to repeal the ACA. Although Congress modified the ACA in 2017 by reducing to zero the tax penalty imposed on individuals for failure to purchase ACA-compliant insurance (*see* Pub. L. 115-97 § 11081, 131 Stat. 2054, 2092 (2017)), it did so only after being informed by the Congressional Budget Office that a mandate penalty was ***not*** essential to operation of the statute.[22] Congress also considered and

[18] *Id*. at 75,317.

[19] *Id.* at 75,317-18.

[20] *Id.* at 75,318.

[21] *Id.*

[22] Before Congress acted, the CBO reported that if the mandate penalty were repealed (or the mandate eliminated altogether), "[n]ongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade." CBO, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* (Nov. 2017), at 1.

declined to adopt numerous proposals to repeal the statute altogether,[23] and declined to repeal or modify the ACA's protections for individuals with pre-existing conditions and its prohibition against discrimination in setting health insurance premiums.[24]

Soon after these ACA repeal efforts failed, President Trump signed Executive Order 13813 on October 12, 2017,[25] seeking to encourage expanded access to STLDI plans specifically because such plans are exempt from the "insurance mandates and regulations included in title I of the [ACA]"; the Order sought to make STLDI plans an "alternative" to ACA-compliant health care for consumers in the individual insurance marketplaces.[26] The proposed STLDI Rule, issued on February 21, 2018—which permitted STLDI plans to last for up to a year and to be renewed three times—was the Departments' response to the President's directive.[27]

The Departments received approximately 12,000 comments on their proposed rule.[28] One analysis found that "more than 98%—or 335 of 340—of the healthcare groups that commented on the proposal to loosen restrictions on short term health plans criticized it, in many cases warning that the rule could gravely hurt sick patients," while "[n]ot a single group representing patients, physicians, nurses or hospitals voiced support" for the proposal.[29] Nevertheless, and

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[23] *See* American Health Care Act of 2017, H.R. 1628 (2017); Better Care Reconciliation Act of 2017, S. Amend. 270 (July 25, 2017); Obamacare Repeal Reconciliation Act of 2017, S. Amend. 271 (July 25, 2017); Healthcare Freedom Act of 2017, S. Amend. 667 (July 26, 2017).

[24] Budget Fiscal Year 2018, 131 Stat. 2054, 2092 (Dec. 22, 2017).

[25] Exec. Order No. 13813, Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States (Oct. 12, 2017), perma.cc/VM65-EXTU.

[26] *Id.*

[27] *Short-Term, Limited-Duration Insurance*, 83 Fed. Reg. 7437 (Feb. 21, 2018).

[28] *Short-Term, Limited-Duration Insurance*, 83 Fed. Reg. 38,212 (Aug. 3, 2018).

[29] Noam N. Levey, *Trump's New Insurance Rules are Panned by Nearly Every Healthcare Group that Submitted Formal Comments*, L.A. Times, May 30, 2018.

notwithstanding many other objections, the Departments "finalized the proposed rule with some modifications" on August 3, 2018.[30]

"Under this final rule, short-term, limited-duration insurance means health coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total."[31] The Departments also clarified that "[n]othing in this final rule precludes the purchase of separate insurance contracts that run consecutively, so long as each individual contract is separate and can last no longer than 36 months."[32] Consequently, the final rule permits the purchase of STLDI coverage that is just short of a year in length, may be renewed or extended so that it remains in effect for up to three years, and—through the use of consecutive contracts—can be structured so that, as a practical matter, it has ***no*** mandated stopping point.

The Departments identified no changed circumstances (whether factual or legal) justifying this deviation from their contrary conclusions in the 2016 STLDI rulemaking, which had taken place less than two years earlier. They did, however, make plain that the change in definition was intended to develop an alternative STLDI health insurance market that would compete with ACA-compliant plans: the avowed purpose of the Rule is to provide a (previously illegal) alternative to ACA-compliant coverage. *See* 83 Fed. Reg. at 38,218 (describing intent to treat STLDI plans as "an additional choice for many consumers that exists side-by-side with individual market coverage"); *id*. (purpose of Rule is "to expand more affordable coverage options to consumers who desire and need them, [and] to help individuals avoid paying for

[30] 83 Fed. Reg. at 38,214.

[31] *Id.* at 38214-15.

[32] *Id.* at 38220.

benefits provided in individual health insurance coverage that they believe are not worth the cost"); *id.* at 38,229 (asserting that the rule "will benefit consumers who have been most harmed by PPACA"); Julia Limitone, *Affordable Health Care is Here: HHS Sec. Alex Azar*, Fox Bus. (Aug. 2, 2018) (quoting HHS Secretary Alex Azar: "What we are doing is bringing cheap and more affordable options to individuals who are trapped under the Affordable Care Act."), goo.gl/kRgEiy; Twitter post by @HHSGov (Aug. 2, 2018), goo.gl/htivgp (video of speech by Secretary Azar: "What people need to know is President Trump is fulfilling his promise to deliver affordable options to individuals. So here, 50 to 80% lower cost than the plans that are already on the market."); U.S. Dep't of Health and Human Servs., *Trump Administration Delivers on Promise of More Affordable Health Insurance Options* (Aug. 1, 2018), goo.gl/PCtqf7 (statement of Secretary Azar that STLDI Rule provides "a much more affordable option for millions of the forgotten men and women left out by the current system").[33] And obviously, a Rule that allows STLDI plans to be renewed for up to three years and to be stacked so that they continue in perpetuity could have no rationale ***other*** than to create a primary insurance product that competes with ACA-compliant plans.[34]

The consequences of the final rule are addressed in detail below. Certain effects are not debatable: The Departments themselves acknowledged that the rule will make "relatively young, relatively healthy individuals in the middle-class and upper middle-class" "more likely to

[33] In this respect, the Rule implemented the goal expressly articulated by President Trump: the administration—unable to obtain repeal of the ACA—has set out "doing it, piece by piece, [the ACA] is just being wiped out." Peter Sullivan, *Trump: ObamaCare Being Wiped Out 'Piece By Piece,'* The Hill (Feb. 23, 2018), goo.gl/jq3rnf.

[34] Guidance issued by the Treasury Department shortly after the Rule became final confirms that the government intends statutory waivers to allow use of STLDI plans as alternatives to ACA-compliant coverage. *See State Relief and Empowerment Waivers*, https://federalregister.gov/d/2-018-23182.

purchase short-term, limited-duration insurance," so "the proportion of healthier individuals in the [ACA-compliant individual market] . . . will decrease."[35] This conclusion is widely shared, including by the American Academy of Actuaries: "Because of medical underwriting at issue, STLD is expected to attract healthier individuals with a lower premium and could put upward pressure on ACA rates as healthier enrollees leave the ACA pool."[36]

According to the Departments' own initial estimates, which a number of commenters noted were unduly optimistic, "premiums for unsubsidized enrollees in the Exchanges will increase by 5 percent" as a result of this change.[37] Another model, which accounted for several under-counting errors in the Departments' estimates, calculates that the Rule will lead ACA enrollment to decrease by 8.2-15.0%, as premiums increase by 2.2-6.6% in the near term.[38]

5. Continuing STLDI plan deficiencies. Commenters also noted the risks that STLDI plans pose for consumers—risks that already have come to pass. For example, commenters warned that STLDI plans are frequently marketed as providing ACA-compliant or equivalent coverage, thereby deceiving consumers into thinking that these plans offer more coverage than they actually do. Indeed, comments submitted in response to the Proposed Rule noted that STLD sales agents will flat-out "contact an individual and tell them that the plan complies with the ACA when it does not."[39] One study conducted after the Rule's promulgation confirms that this

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[35] *Id.* at 28235.

[36] Comment of American Academy of Actuaries, Apr. 6, 2018, at 5, https://www.regulations.gov/document?D=CMS-2018-0015-1409.

[37] 83 Fed. Reg. at 28235.

[38] Wakely Consulting Group, *Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market,* perma.cc/T8RE-4F37.

[39] Comment of Families USA, at 2 (Apr. 23, 2018), goo.gl/cmqcQA; *see also, e.g.*, Reed Abelson, *Without Obamacare Mandate, 'You Open the Floodgates' for Skimpy Health Plans*, N.Y. Times (Nov. 30, 2017), https://goo.gl/pCcqoG ("[S]ome brokers are deliberately promoting [STLDI] policies without pointing out that they do not meet the same levels of coverage of

is the case, finding that "consumers shopping online for health insurance, including those using search terms such as 'Obamacare plans' or 'ACA enroll,' will most often be taken to websites and brokers selling STLDI or other non-ACA compliant products."[40] That study further noted that the brokers "selling STLDI over the phone push consumers to purchase the insurance quickly, without providing written information."[41]

This situation facilitates abuse. In response, more than 20 States have already warned consumers about the misleading advertising and exclusion-riddled nature of STLD plans.[42] But the States have acknowledged that their best efforts will not prevent harm to consumers because they "lack comprehensive data about which insurers actively market STLDI to their residents," "generally lack the authority and/or capacity to engage in preemptive regulatory oversight that

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A.C.A. plans, said Scott Flanders, the chief executive of eHealth. 'They're selling the hell out of it,' he said.").

[40] Sabrina Corlette et. al, *The Marketing of Short-Term Health Plans*, at 2 (Georgetown University Health Policy Institute Jan. 31, 2019), *available at* https://rwjf.ws/2Sybdv2.

[41] *Id.*

[42] *See, e.g.*, Alaska Division of Insurance, *2018 Individual Health Plan Enrollment*, https://bit.ly/2pJjn49; Consumer Alert, Arkansas Insurance Department (Nov. 8, 2018), https://bit.ly/2ttSToJ; Enrolling in Marketplace Coverage for 2019, Indiana Department of Insurance, https://bit.ly/2SOaWF7; Consumer Alert, Iowa Insurance Division (Dec. 12, 2017); https://bit.ly/2SePWlJ; Consumer alert, Kansas Insurance Department (Nov. 1, 2018), https://bit.ly/2SOWBZd; Consumer Alert, Kentucky Insurance Department, https://bit.ly/2SfG6A2; Short-Term, Limited Duration Insurance, Montana State Auditor, https://bit.ly/2BLRm1K; Short-Term Health Insurance Plans, Maine Bureau of Insurance, https://bit.ly/2IpaMiT; Is a Short-Term Medical Plan for You, Maryland Insurance Administration, https://bit.ly/2GW3TTJ; Short-Term Limited Duration Health Plans in Minnesota, Minnesota Commerce Department, https://bit.ly/2BKx7S1; Buyer Beware: Considering Alternative Options for 2019 Health Coverage, New Hampshire Insurance Department, https://bit.ly/2txT2aS; Consumer Alert, Ohio Department of Insurance (Oct. 31, 2018), https://bit.ly/2TYzkk7; Understand your health insurance, Oregon Division of Financial Regulation, https://bit.ly/2IsArqM; What you need to know about short-term medical plans, Washington State Office of the Insurance Commissioner, https://bit.ly/2TYVK4K; Qualified Health Plan versus Short-Term Plan, West Virginia Offices of the Insurance Commissioner (Sept. 21, 2018), https://bit.ly/2SeWfFV; In the matter of: Short-Term Limited Duration Policies, State of Michigan Department of Insurance and Financial Services (Sept. 14, 2018), https://bit.ly/2E1Xbs7; Press Release, Rhode Island Governor Raimondo (Aug. 2, 2018), https://bit.ly/2Sj7Kwo.

would prevent deceptive marketing tactics before they occur," and often cannot enforce their marketing standards retroactively "because little of the purchase transaction is documented in writing."[43] Moreover, another study found that "many short-term plans are being sold through out-of-state associations that are exempt from state regulation," a "backdoor approach" to STLDI marketing that makes it difficult, if not impossible, for States to protect in-state consumers from deceptive marketing of the STLDI plans directed at them.[44]

As a result, these consumers will be exposed to the very range of abuses against which the ACA was designed to protect, including coverage exclusions, rescissions, and annual and lifetime benefit caps. Compounding the problem, the benefit caps of STLDI plans often reset when the plan expires, meaning that "deductibles, waiting periods, maximum benefit limits and maximum out-of-pocket obligations will reset" during the following year, and "any illness or condition [consumers] develop under [their] current policy will be considered a pre-existing condition" the following year.[45]

Coverage exclusions are problematic for a similar reason: STLDI plans frequently do not cover services that healthy individuals may find that they need only after purchasing the plan. To take the most obvious example, one study found that ***no*** available STLDI plans cover maternity care.[46] But an entire nine-month pregnancy fits easily within a 364-day STLDI term, and consumers covered only by STLDI would therefore be left with a choice between spending thousands of dollars out of pocket or forgoing needed care.

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[43] Corlette et. al., *supra*, at 2.

[44] Emily Curran et. al, *Short-Term Health Plans Sold Through Out-of-State Associations Threaten Consumer Protections*, The Commonwealth Fund (Jan. 31, 2019), *available at* https://bit.ly/2IsjNYk.

[45] Everest FlexTerm Health Insurance Brochure at 4, https://bit.ly/2BJluuW.

[46] Karen Pollitz et al., *Issue Brief: Understanding Short-Term Limited Duration Health Insurance*, Kaiser Family Foundation (Apr. 23, 2018), perma.cc/GX37-G7A6.

Rescissions—retroactive cancellations of coverage—are likewise prohibited for ACA Marketplace plans, but not for STLDI plans. In testimony before the House Ways and Means Committee earlier this year, one witness described his experience with an STLDI plan, which demanded reams of documentation—including files from a pediatrician the witness had not "seen in over 15 years"—before acquiescing to the State of California's demand that the plan pay for his life-saving heart surgery.[47] The ACA-compliant plan that the witness now uses—and which the final regulation promulgated by Defendants will make more expensive and harder for him to maintain—paid for the care necessary to save his life, and continues to ensure that he will be healthy.[48] This witness's experience, as the administrative record before the Departments confirms, is hardly unusual. One comment on the Proposed Rule reflects the story of an Illinois woman who suffered extreme vaginal bleeding, losing half her blood and requiring an emergency hysterectomy and a five-day hospital stay. Her short term insurance provider refused to pay any of the resulting medical bills—which amounted to tens of thousands of dollars—claiming that her regular menstrual cycle constituted a pre-existing condition.[49] Similarly, a San Diego man had a heart attack and required a $900,000 triple-bypass surgery, but his STLDI plan refused to pay for it, maintaining that he failed to disclose pre-existing medical conditions for which he had not been diagnosed.[50]

6. Procedural history. Plaintiffs are associations of insurers, health care providers, and entities that assist and advocate for individuals who have medical conditions or otherwise use medical services. All participated in the 2018 rulemaking proceeding and/or believe strongly that

[47] Written Testimony of Andrew Blackshear Before the House Ways and Means Committee, Hearing on "Protecting Americans with Pre-existing Conditions," at 4 (Jan. 29, 2019).

[48] *Id.* at 5.

[49] Comment of EverThrive Illinois, at 2 (Apr. 23, 2018), goo.gl/j21Noe.

[50] *See* Abelson, *supra* n. 39.

the STLDI Rule both will injure them directly and is incompatible with their shared purpose of ensuring access to adequate, affordable health care for all Americans. They filed the complaint in this suit on September 14, 2018, contending that the STLDI Rule is (1) inconsistent with the ACA's terms structure, and manifest purpose, and (2) is arbitrary and capricious is several respects. Each plaintiff and its members and/or the individuals and groups that it represents will suffer significant and irreparable harm from the STLDI rule.[51]

Plaintiffs initially moved for a preliminary injunction. After briefing and argument, however, and in light of likelihood that the motion could not be resolved prior to the close of the ACA 2019 open enrollment period, plaintiffs withdrew that motion. They now seek summary judgment and a determination that the STLDI Rule is invalid.

ARGUMENT

When enacting the ACA, Congress could have chosen to—but did not—adopt a policy allowing people to buy threadbare health plans that declined to cover essential services. Congress could have chosen to—but did not—create a scheme in which people who buy health coverage could be saddled with ruinous medical debt. And Congress could have chosen to—but did not—continue permitting health-insurance markets to impose prohibitive premiums upon, and effectively exclude, those with pre-existing conditions.

[51] The Departments' challenge to Plaintiffs' standing, advanced at the preliminary injunction stage, is insubstantial. In addition to other bases of standing, the insurer plaintiffs, who are losing and will continue to lose subscribers to STLDI plans authorized by the Rule, may proceed under the doctrine of competitor standing. *See*, *e.g.*, *Wash. All. of Tech. Workers v. DHS*, 892 F.3d 332, 341 (D.C. Cir. 2018); *Sherley v. Sebelius*, 610 F.3d 69, 72 (D.C. Cir. 2010); *Associated Gas Distribs. v. FERC*, 899 F.2d 1250, 1258 (D.C. Cir. 1990). That is sufficient to allow the case to proceed: It is axiomatic that, in a multi-plaintiff case, only "one plaintiff must have standing to seek each form of relief requested." *Town of Chester v. Laroe Estates*, 137 S. Ct. 1645, 1651 (2017).

Instead, Congress in the ACA established three key rules that allow everyone—sick and healthy alike—to obtain affordable coverage. Two of those rules are the guaranteed-issue and community rating requirements, which are made workable only because all covered persons participate in a single health insurance market. The third is the obligation that every plan in this market offer minimum "essential" protections.

Dissatisfied with the ACA, the Departments have sought to circumvent the statute's requirements by creating an alternative health insurance regime. They have not been subtle about this: the Rule itself declares its intent to create a health insurance system that "exists side-by-side with individual market coverage" and the Secretary of HHS repeatedly has trumpeted the point. But federal agencies may not adopt a regulation that has the purpose and effect of undermining a regime enacted by Congress, based on agency preferences that are directly contrary to the congressional judgments embodied in statute— and that Congress repeatedly has declined to enact.

Under the Administrative Procedure Act, courts must "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). Here, the STLDI Rule should be vacated under the APA because it is unlawful for at least three reasons: (1) under both steps one and two of the analysis stated in *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837 (1984), the Departments exceeded their authority by promulgating a rule that departs from the individual health insurance market structure established by Congress in the text and structure of the ACA; (2) the Departments' interpretation of "short term" and "limited duration" is contrary to the plain meaning of and intent behind the statutory text; and (3) the STLDI Rule is arbitrary and capricious because the Departments failed either to offer a reasoned explanation for their

departure from the 2016 Rule or a meaningful response to critical comments on the Rule as it was proposed. Accordingly, the STLDI Rule should be set aside.

I. THE STLDI RULE IS INVALID AS NOT IN ACORDANCE WITH LAW.

A. The Departments Lack Authority To Issue The STLDI Rule, Which Conflicts With Congress's Legislative Judgments Embodied In The ACA.

It is fundamental that federal agencies may not issue rules that conflict with the statutes that the agencies are purporting to apply. "A reviewing court must reject administrative constructions of [a] statute . . . that are inconsistent with the statutory mandate or that frustrate the policy that Congress sought to implement." *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144 (D.C. Cir. 1986) (alterations in original) (internal quotation marks omitted); *see*, *e.g.*, *Chem. Mfrs. Ass'n v. Nat. Res. Def. Council, Inc.*, 470 U.S. 116, 125 (1985) ("[I]f Congress has clearly expressed an intent contrary to that of the Agency, our duty is to enforce the will of Congress."); *Chevron*, 467 U.S. at 843 n.9 ("The judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear congressional intent."); *La. Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 375 (1986); *Central United Life*, 827 F.3d at 73.

Congress exercised its legislative power in the ACA to structure the individual health insurance market in a specified manner that it determined would improve access to health care. The Departments' power and discretion to act are constrained by that statutory determination. Because the STLDI Rule contravenes and undercuts Congress's judgment, embodied in the text and structure of the ACA, the Rule is contrary to law.

1. The STLDI Rule Exceeds The Departments' Authority Because It Departs From The Requirements Imposed By Congress To Govern the Individual Insurance Market.

a. To begin with, Congress in the ACA spoke to the very questions that the Departments now claim to be addressing, making clear that the Departments may not establish STLDI as an alternative to ACA-compliant insurance. This reality is fatal to the government's defense of the Rule.

When reviewing an agency's construction of the statute that it administers, courts must first determine "whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter." *Chevron*, 467 U.S. at 842-43. That principle resolves this case. Here, the statutory scheme created by the ACA unambiguously precludes precisely what the Departments seek to do.

In the ACA, Congress enacted a comprehensive system for "expand[ing] more affordable coverage options to consumers who desire and need them" and "reduc[ing] the number of uninsured individuals" (83 Fed. Reg. at 38,218)—the purported goals of the STLDI Rule. But Congress determined that the way to accomplish these ends is through the requirements of guaranteed issue and community rating (*see* 42 U.S.C. 300gg-1, 300gg-3, 300gg-4(a); §§ 300gg(a)(1), 300gg-4(b)), assuring that all health insurance consumers would be "members of a *single* risk pool." 42 U.S.C. § 18032(c). It specifically prohibited insurers from refusing coverage to individuals with preexisting conditions, and from setting premiums based on individuals' health history, gender, and other factors. Congress stated these goals expressly and in the strongest terms: it designed the ACA to "minimize . . . adverse selection and broaden the health insurance risk pool to include healthy individuals," which would "lower health insurance premiums" and create "effective health insurance markets" that contain "improved health insurance products" and expand access to quality affordable health care for all. 42 U.S.C. §

18091(2)(I). The STLDI Rule, by contrast, attempts to make STLDI plans—which are exempt from all of these requirements—substitutes for ACA-compliant plans. The Rule, which would ***increase*** adverse selection, cannot be reconciled with these goals: it adopts the approach that Congress specifically rejected.

Congress also addressed whether the federal government should "help individuals avoid paying for benefits provided in individual health insurance coverage that they believe are not worth the cost" (83 Fed. Reg. at 38,218)—another asserted goal of the STLDI Rule. Congress unambiguously answered ***no***, codifying in the ACA its judgment that all individuals should receive coverage for certain essential health benefits in order to assure access to necessary health care. *See* 42 U.S.C. §§ 300gg-6(a), 18022(b). There is no doubt that Congress regarded such benefits as a crucial element of the reformed insurance market; after all, it labeled them "essential." And here again, the STLDI Rule, which will vastly expand the use of what Congress expressly declared to be ***inadequate*** insurance products, implements a policy that Congress specifically rejected in the text of the ACA.

There is no room to doubt that Congress meant for the ACA to create a single, coherent market that provides specified health insurance benefits. In interpreting statutes to determine whether Congress has spoken directly on a question, the Supreme Court has admonished that it is important to respect the "fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000). "In determining whether Congress has specifically addressed the question at issue, the court should not confine itself to examining a particular statutory provision in isolation. Rather, it must place the provision in context, interpreting the statute to create a symmetrical and coherent regulatory scheme." *Id.* at

121; *see also Bell Atl. Tel. Cos. v. FCC*, 131 F.3d 1044, 1048 (D.C. Cir. 1997) (looking to "the history, structure, and underlying policy purpose of the statute").

This is particularly important in a statute like the ACA, where the major provisions are "interdependent" and expressly note that they work "together with the other provisions of [the] Act." *See NFIB*, 567 U.S. at 696 (Scalia, J., dissenting); *see also* 42 U.S.C. § 18091(2)(C) (working "together" to "add millions of new consumers to the health insurance market"); *id.* § 18091(2)(E) (working "together" to "significantly reduce" the economic cost of the "poorer health and shorter lifespan of the uninsured"); *id.* § 18091(2)(F) (working "together" to "lower health insurance premiums"); *id.* § 18091(2)(G) (working "together" to "improve financial security for families"); *id.* § 18091(2)(I) (working "together" to minimize "adverse selection and broaden the health insurance risk pool to include healthy individuals"); *id.* § 18091(2)(J) (working "together" to "significantly reduce administrative costs and lower health insurance premiums"). The reasoning that underlies the STLDI Rule simply disregards—and does violence to—this statutory structure.

b. The conflict between the Rule and Congress's intent is confirmed by the extraordinary nature of the change that the departments would effect through the STLDI Rule. To determine whether Congress has spoken to a question, courts employ "traditional tools of statutory construction" (*Chevron*, 467 U.S. at 843 n.9)—including "all pertinent interpretive principles." *Carter v. Welles-Bowen Realty, Inc.*, 736 F.3d 722, 731 (6th Cir. 2013) (Sutton, J., concurring). "If an interpretive principle resolves a statutory doubt in one direction, an agency may not reasonably resolve it in the opposite direction." *Id*. And one such principle is that courts "expect Congress to speak clearly if it wishes to assign to an agency decisions of vast 'economic and

political significance.'" *King*, 135 S.Ct. at 2489; *Util. Air Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2444.

Here, that is just what the Departments would accomplish with the STLDI Rule: They purport to create a new form of primary health insurance that is exempt from all of the ACA's central requirements, so as to draw what the HHS Secretary has himself described as "millions" of people out of what Congress intended to be a single market, while also vastly expanding the number of individuals who purchase insurance that lacks the characteristics Congress regarded as "essential." *See* 83 Fed. Reg. 38,212. That will have an enormous impact on the structure and economics of the individual insurance market and the innumerable people who obtain health insurance through it—subjects that have been the center of heated political debate for decades. *See, e.g, Timeline: History of Health Reform in the U.S.*, Kaiser Family Foundation (2011), perma.cc/539M-4QFY.

But the Departments do not, and cannot, identify any clear and specific congressional grant of authority to unilaterally restructure the nationwide individual insurance market and determine whether and how much insurance individuals should purchase. The Departments rely instead only on their authority to define undefined statutory terms based on a generalized "necessary and appropriate" clause in the Public Health Services Act. *See* 83 Fed. Reg. at 32,215. It surely is implausible to suggest that Congress intended to delegate such sweeping and contentious authority to the Departments through a vague and generalized "necessary and appropriate" provision and a single undefined statutory term: As the Supreme Court has put it, Congress "does not, one might say, hide elephants in mouseholes." *Whitman v. Am. Trucking Ass'ns, Inc.*, 531 U.S. 457, 468 (2001).

2. The STLDI Rule Advances An Unreasonable Interpretation Of "Short Term Limited Duration Coverage."

Even assuming *arguendo* that the Departments possess some discretion in determining the types of primary health insurance that should be available to consumers in the individual market, the Departments did not reasonably exercise that discretion in promulgating the STLDI Rule. At step two of the *Chevron* inquiry, courts "must reject administrative construction of [a] statute . . . . that frustrate[s] the policy that Congress sought to implement." *Shays v. Fed. Election Comm'n*, 528 F.3d 914, 919 (D.C. Cir. 2008); *see also Util. Air Regulatory Grp.*, 134 S. Ct. at 2442 ("[A]n agency interpretation that is 'inconsisten[t] with the design and structure of the statute as a whole' does not merit deference." (quoting *Univ. of Tex. Sw. Med. Ctr. v. Nassar*, 133 S. Ct. 2517, 2529 (2013))). And here, for the reasons outlined above, it is unquestionable that both the purpose and the effect of the STLDI Rule is to frustrate Congress's policy as embodied in the text and structure of the ACA. Accordingly, it is an impermissible exercise of discretion by the Departments.

The purpose of the STLDI Rule is clear: The Departments acknowledge that the Rule was promulgated pursuant to the directive in Executive Order 13813, with the goal of changing the structure of the individual insurance market established by the ACA. *See* pages 11-12, *supra*. And the STLDI Rule would in fact do what it is designed to do, frustrating the purposes and policies of the ACA. As explained above, Congress enacted the ACA to make affordable and adequate health insurance coverage widely available by minimizing adverse selection and "broaden[ing] the health insurance pool to include healthy individuals," placing all covered individuals in a single insurance pool. *See supra* at pages 4-6 (describing essential health benefits and open and special enrollment period requirements). It chose to do so by coupling a prohibition on insurers denying individuals coverage and charging individuals higher premiums based on

their medical history (42 U.S.C. §§ 300gg(a)(1), 300gg-1, 300gg-3, 300gg-4(a), 300gg-4(b)) with subsidies and tax incentives to assist individuals in purchasing insurance. 26 U.S.C. §§ 36B, 5000A. Congress added to this the guarantee that all persons buying health insurance in the individual market would receive "essential" insurance benefits. For this reform to work as an economic matter, Congress deemed it necessary to minimize adverse selection and "broaden the health insurance pool to include healthy individuals," placing all covered individuals in a single insurance pool. 42 U.S.C. § 18091(l); *see also supra* at pages 6-7 (describing essential health benefits and open and special enrollment period requirements).

But the Departments ***concede*** that the STLDI Rule frustrates all of these policies. It directly undoes the congressional intent to "broaden the health insurance pool to include healthy individuals" (42 U.S.C. § 18091(l)) and to create a "single risk pool" in the individual market (*id.* § 10832). The Departments acknowledge that the Rule intends to make STLDI "an additional ... option that may be available to [individuals]." 83 Fed. Reg. 38,218. This is a recognition that the Rule will "lead to adverse selection," with "relatively young, relatively healthy individuals in the middle-class and upper middle-class" "more likely to purchase short-term, limited duration insurance," so "the proportion of healthier individuals in the individual market Exchanges will decrease." *Id.* at 38,235. The Departments further recognize that this adverse selection will in turn cause "premiums for unsubsidized enrollees in the Exchanges [to] increase by 5 percent" (an estimate which, as discussed above, is unreasonably optimistic). *Id.* These rising costs will, in turn, encourage more people to defer purchasing coverage until they are ill, which will put further upward pressure on premium costs, until insurers must either "significantly increase premiums" or simply exit the market, resulting in a self-perpetuating death spiral. *Sebelius*, 567

U..S. at 548.[52] Again, the Departments acknowledge this: The Rule may result in "fewer issuers . . . offer[ing] plans in the individual market." 83 Fed. Reg. 38,233. At the same time, an express goal of the Rule is to allow insurers to strip from STLDI policies—now made primary forms of insurance—the benefits that Congress deemed "essential.

The Departments have taken this step because they disagree with the statutory scheme that Congress created, openly declaring their intent to develop a parallel market, outside the ACA's single risk pool, in which coverage is not assured and essential benefits are not guaranteed. *See*, *e.g.*, 83 Fed. Reg. at 38,216 ("this regulatory action is necessary and appropriate to remove federal barriers that inhibit consumer access to additional, more affordable coverage options"); *id.* at 38,218 ("the availability of short-term limited-duration insurance provides an additional choice for many consumers that exists side-by-side with individual market coverage"). But they are "not free to substitute new goals in place of the statutory objectives without explaining how these actions are consistent with [their] authority under the statute." *Indep. U.S. Tanker Owners Comm. v. Dole*, 809 F.2d 847, 854 (D.C. Cir. 1987). And the Departments are wholly unable to explain how the statutory goals are consistent with a Rule that will result in many Americans being unable to obtain the coverage they need to treat their medical conditions and that results in many others obtaining policies that lack "essential" features; an interpretation of the ACA that undermines and destabilizes the marketplace and protections put into place by Congress simply cannot qualify as reasonable.

[52] By the Departments' own estimate, the STLDI Rule will cause enrollment in individual market plans to decrease by 1.3 million by 2028. 83 Fed. Reg. at 38,236. This likely is a drastic understatement of the Rule's real effect; as discussed above, independent experts estimate that ACA enrollment will decrease by 8.2-15%. *See* page 13, *supra*; *see also* Urban Institute, *Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending*, 2 (Mar. 2018).

3. The Departments' Defenses Of The Rule Are Wrong.

In seeking to defend the Rule when opposing Plaintiffs' motion for a preliminary injunction, the government purported to seek support in elements of the statutory language and policy. None of these contentions has merit.

First, the government maintained that the STLDI Rule must be consistent with the ACA because the ACA contains an STLDI exemption. *See* Preliminary Injunction Opp. 27. But this circular argument assumes its conclusion; the dispositive question is ***what the STLDI exemption means***. Answering that question requires looking to how Congress used the STLDI exemption in the broader context of the ACA. And as we explain elsewhere (*see* pages 31-33), Congress authorized use of STLDI in the ACA as a limited gap-filler and ***not*** as an alternative form of primary insurance.

Second, the government argued that, because the ACA recognizes "various alternatives to ACA-compliant coverage"—including, in addition to STLDI plans, such coverage options as grandfathered pre-ACA plans and student health insurance plans—the STLDI Rule's vast expansion of "alternatives to ACA-compliant insurance" also is permissible. Preliminary Injunction Opp. 35; *see id*. at 32-33 & n.24. This argument, however, again squeezes an enormous elephant into a tiny mouse-hole. The statutory exceptions to ACA-compliant coverage identified by the government all are both narrow and self-limiting, as is (as it was used historically) the STLDI exemption itself, and therefore are consistent with the ACA's general attempt to limit adverse selection and market segmentation. By contrast, the Departments' Rule expressly conceptualizes STLDI as a generally available insurance alternative for millions of consumers who seek to evade the ACA's requirements and wish to remain outside the ACA's single risk pool. That approach is fundamentally inconsistent with Congress's conception of the ACA. "Congress passed the Affordable Care Act to improve health insurance markets, not to

destroy them," and defendants are bound to "interpret the Act in a way that is consistent with the former, and avoids the latter." *King v. Burwell*, 135 S. Ct. 2480, 2496 (2015). The STLDI Rule cannot survive application of that principle.

Third, the government has suggested that the STLDI Rule is consistent with the ACA's goal of increasing insurance coverage because it offers an option for individuals who already intend to forgo ACA-compliant coverage in any event, and who therefore otherwise would have no health insurance at all. But this contention is wrong as a factual matter: the Departments themselves have recognized that the options newly made available by the STLDI Rule will draw more than a million people out of ACA compliant plans over the next decade, an estimate that, as we have shown, likely is substantially understated. *See* page 12-13, *supra*. Moreover, as we also have shown (13-16, *supra*), Congress would not have regarded STLDI plans as offering meaningful coverage; many of those plans lack benefits that Congress considered "essential" or otherwise are unsuitable as primary forms of insurance. The STLDI Rule thus sabotages, rather than supplements, the ACA's goals.

B. The Departments' Interpretation Of "Short Term" To Include Plans That Are Virtually As Long As Standard Insurance Plans Is Contrary To Law.

Against this background, it is unsurprising that the Departments' efforts to shoehorn their inconsistent policy goals into the phrase "short-term limited duration insurance" as used in HIPAA and the ACA also is contrary to the plain meaning of the statutory text. Here, the language, purpose, and context of Congress's use of the term "short term limited duration insurance" all demonstrate that "short term" does not mean a period that is virtually equivalent to the term of a standard annual health insurance plan. Accordingly, the Department's interpretation of that term must be set aside as "not in accordance with law." *See, e.g., Am. Fed'n of Labor &*

Congress of Indus. Orgs. v. Fed. Election Comm'n, 177 F. Supp. 2d 48, 55 (D.D.C. 2001); *Am. Bankers Ass'n v. Nat'l Credit Union Admin.*, 271 F.3d 262, 267 (D.C. Cir. 2001).

1. The Departments' Interpretation Of "Short Term" Is Contrary To The Statutory Text.

The plain meaning of the phrase "short term" is unambiguous: it means "occurring over or involving a relatively short period of time." *Short-term*, Merriam-Webster Dictionary, perma.cc/4ZCF-QPLQ. As that definition makes clear, the term is relative.[53] And here, the relevant benchmark is the length of a standard health insurance plan: one year. *See, e.g.,* 42 U.S.C. 13031 (requiring American Health Benefit Exchanges to provide for "annual open enrollment periods"); *Definition of Health Insurance Terms*, Bureau of Labor Statistics, perma.cc/T3MF-SFBU (noting that a benefit period is "usually a year"); *Glossary of Health Insurance Terms*, Med. Mut., perma.cc/H4WX-VCPR (defining "benefit period" and explaining that "[i]t is often one calendar year for health insurance plans"); *Plan Year*, HealthCare.gov, perma.cc/CV6L-QQAU (defining "plan year" as a "12-month period of benefits coverage under a group health plan").

A "short term" insurance plan, then, is one that involves a "relatively short period of time" as compared to one year. And a term just a day short of one year—*i.e.* more than 99.9 per cent the length of a standard term of health insurance—cannot in any meaningful sense of the word be considered "relatively short."

[53] Something can be "short" only as it relates to the length of something else. For example: A giraffe with a one-foot long neck has a very short neck compared to other giraffes, but a very long neck compared to a person.

2. The Departments' Interpretation Is Contrary To The Congressional Purpose And Statutory Context Of The ACA.

Congress's purpose in defining "individual health insurance coverage" to exclude "short-term limited duration insurance," as well as that term's place within the overall HIPAA and ACA schemes, confirm that "short term" means what it says—and does not mean anything close to a year.

a. Congress enacted HIPAA to increase access to and portability of health insurance coverage for individuals and their families so that they could retain their health insurance when they changed or lost their jobs. *See, e.g.*, S. Rep. No. 104-156, at 1 (HIPAA was intended to "mak[e] it easier for people who change jobs or lose their jobs to maintain adequate coverage"). In particular, Congress was concerned with the large number of Americans who were "at risk of becoming uninsured or subject to preexisting condition exclusions under the current system because they change jobs, lose jobs, or work for employers who change insurance policies." *See id.* at 4. This problem was aggravated in the individual market because, as of the time of HIPAA's enactment, "[m]ost individual insurance policies impose[d] pre-existing condition exclusions or limitations; individuals with chronic health conditions may be entirely denied coverage." H.R. Rep. No. 104-496, at 71 (1996); *see also* S. Rep. No. 104-156, at 7.

Accordingly, with respect to the individual market, Congress sought to ensure that individuals who previously had insurance through a group health insurance plan could maintain adequate coverage if they lost, left, or changed their jobs. S. Rep. No. 104-156, at 2, 4. It did this by (1) prohibiting issuers that offer health insurance coverage in the individual market from declining to offer such coverage, deny enrollment, or apply any preexisting condition exclusion to someone who previously had 18 months of continuous health coverage under a group health plan (subject to certain limitations) (Pub. L. 104-191, § 111, 110 Stat. 1979); and (2) requiring

such issuers to renew individual health insurance coverage at the option of the individual. *Id.*, 110 Stat. 1982. These requirements apply to issuers offering "individual health insurance coverage," which Congress defined to mean *all* "health insurance coverage offered to individuals in the individual market" *except* for "short-term limited duration insurance." *Id.* § 102, 110 Stat. 1973 (codified at 42 U.S.C. § 300gg-91).

As the overall statutory context and legislative background make clear, Congress's purpose in HIPAA was to protect individuals with preexisting conditions and other high risk factors who might lose their coverage and not be able to obtain replacement insurance. Such individuals who had been covered but lost their group health insurance now would be able to obtain coverage (including coverage for those pre-existing conditions) in the individual market. And once an individual had coverage in the individual market, he or she would be able to renew and keep that insurance, even if their health condition worsened, new conditions developed, or new risk factors emerged.

When "short term" is interpreted in accordance with its plain and historic meaning—as relatively brief, gap-filling coverage for people between annual plans who are awaiting commencement of full coverage pursuant to HIPAA's access and portability guarantees—the exception for "short-term limited duration coverage" is consistent with HIPAA's purposes. HIPAA would, as intended, regulate the market for primary health insurance coverage to ensure portability of such coverage, protecting individuals with preexisting condition. But those regulations simply would not apply to STLDI, insurance that was not intended to serve people in an ongoing fashion and where there was no need to assure renewal of the plan into the future.

But interpreting "short term" to include virtual equivalents of standard, annual insurance plans (as the Departments have in the STLDI Rule) frustrates this purpose. It creates a new

market segment where individuals with pre-existing conditions are entirely unprotected, and incentivizes insurers to offer these plans in lieu of regulated "individual health insurance coverage." Individuals with preexisting coverage may not be able to access coverage in this new shadow market, and they may lose such coverage once they have it if their health changes or new conditions emerge—the exact problems that Congress sought to remedy in enacting HIPAA.

b. Moreover, even if Congress had left open under HIPAA whether "short term" could encompass plans that are one day shorter than standard annual plans, it unquestionably foreclosed such an interpretation through the enactment of the ACA. For one thing, the text of the ACA removes any doubt that "short term," as used in "short-term limited duration coverage," has a meaning consistent with its plain meaning—*i.e.*, a period that is relatively shorter than the typical 12-month standard insurance plans. In the ACA, Congress referred to a "short coverage gap[]" that is exempt from the ACA's penalty for failure to maintain minimum essential coverage. 26 U.S.C. § 5000A(e)(4). And Congress expressly defined such a "short coverage gap[]" as a "period of less than 3 months." *Id.* § 5000A(e)(4)(A).

Congress presumptively intended that definition of "short"—as meaning a "period of less than 3 months"—to apply to the same word as used in the phrase "short-term limited duration coverage" (as incorporated by reference in the ACA). "A standard principle of statutory construction provides that identical words and phrases within the same statute should normally be given the same meaning." *Powerex Corp. v. Relian Energy Servs., Inc.*, 551 U.S. 224, 232 (2007). And this canon applies with special force here because the "short coverage gaps" and "short-term limited duration coverage" provisions serve related purposes and complement one another. By exempting from the ACA's penalty "short coverage gaps" of less than three months, Congress expressed its judgment that individuals should not have coverage that falls short of the

ACA's minimum essential coverage requirements for longer than three months. Construing "short-term limited duration coverage," which does ***not*** have to comply with the minimum essential coverage requirements, as including plans that are much longer than three months is irreconcilable with that congressional judgment. *See also* 42 U.S.C. § 300gg-7 (providing that "[a] group health plan and a health insurance issuer offering group health insurance coverage shall not apply any waiting period . . . that exceeds 90 days").

In contrast, there is ***no*** indication that Congress regarded "short term" plans as suitable for satisfying individuals' primary and permanent health insurance needs—a reading, as noted above, that would run counter to the ACA's central goals. It is hardly likely that Congress would have used the phrase "short term" as a counter-intuitive mechanism for circumventing the ACA's principal objective. There is no ambiguity on this point. "Ambiguity … 'is a creature not of definitional possibilities but of statutory context.' *Brown v. Gardner*, 513 U.S. 115, 118 (1994). [And] [s]een in its proper context, [the STLDI Rule] clearly misreads the [ACA]." *Central United Life*, 827 F.3d at 74.

c. In advancing its contrary reading, the government has contended that Congress, in the ACA, meant to ratify the definition of STLDI as encompassing plans with a duration of less than a year that the Departments initially adopted in 1997 for use in connection with HIPAA. This contention is incorrect, for several reasons.

First, we note that, even if correct, the government's argument would itself require partial invalidation of the STLDI Rule because the pre-ACA STLDI definition did not permit ***any*** renewal of STLDI plans. Consequently, if Congress truly intended to incorporate the Departments' 1997 STLDI definition in the ACA, the statute would preclude the current Rule's novel authorization of repeated plan renewal.

Second, the Departments did not invoke this ratification canon in their rulemaking. Consequently, they may not shore up their work now by presenting it for the first time in briefing before this Court. *See Nat'l Fuel Gas Supply Corp. v. FERC*, 468 F.3d 831, 839 (D.C. Cir. 2006) ("[T]he grounds upon which the agency acted in exercising its powers [must be] those upon which its action can be sustained."). In fact, the Departments' omission on this score when they promulgated the Rule does not appear to have been accidental; as noted above, reliance on a ratification rationale would have barred the Departments from purporting to authorize renewals of STLDI plans.

Third, and more fundamentally, the government's ratification argument is flawed on its own terms. "Although [the Supreme Court has] recognized congressional acquiescence to administrative interpretations of a statute in some situations, [it has] done so with extreme care." *See Solid Waste Agency of N. Cook Cty. v. U.S. Army Corps of Eng'rs*, 531 U.S. 159, 169 (2001). The Court accordingly has required "overwhelming evidence of acquiescence" before it would be willing "to replace the plain text and original understanding of a statute with an amended agency interpretation." *Id.* at 169 n.5. At a minimum, the ratification doctrine "requires a showing of both congressional awareness and ***express*** congressional approval of an administrative interpretation if it is to be viewed as statutorily mandated." *Gen. Am. Transp. Corp. v. ICC*, 872 F.2d 1048, 1053 (D.C. Cir. 1989) (emphasis added) (quotation marks omitted).

Here, however, there is ***no*** evidence that Congress was aware of and intended to incorporate the pre-ACA HIPAA regulation, thus exempting 364-day plans from the ACA's reforms. In fact, there is no "indication [that] Congress considered th[at] interpretation" ***at all.*** *Koszola v. FDIC*, 393 F.3d 1294, 1299 (D.C. Cir. 2005). The government cites no evidence from the legislative debates surrounding the ACA—and we are aware of none—indicating that

Congress was even aware of the definition of a "short-term limited duration" plan that the Departments had applied in the quite different context of HIPAA's continuing coverage rules, let alone that Congress approved of that definition. That likely is because, as we demonstrate above (at 3-4), the STLDI definition as it related to HIPAA was of very limited importance, was not discussed by the Departments in the promulgation of the HIPAA STLDI rule, and was the subject of ***no*** public comments.

And because Congress did not amend the specific statutory at language at issue here, there is no basis for inferring that Congress had the prior agency interpretation in mind when it enacted the ACA. *See Pub. Citizen, Inc. v. HHS*, 332 F.3d 654, 668 (D.C. Cir. 2003) (ratification canon is of "little assistance" where Congress did not amend statutory language at issue); *Cape Cod Hosp. v. Sebelius*, 630 F.3d 203, 214 (D.C. Cir. 2011) (ratification cannon "has little relevance" where Congress did not reenact the specific section at issue). "[A]bsent some evidence of (or reason to assume) congressional familiarity with the administrative interpretation at issue," the ratification canon carries "little weight." *Pub. Citizen, Inc.*, 332 F.3d 654, 669 (D.C. Cir. 2003); *see also Brown v. Gardner*, 513 U.S. 115, 121 (1994) (where "there is no . . . evidence to suggest that Congress was even aware of the [agency's] interpretive position[,] . . . we consider . . . re-enactment to be without significance") (quotation marks omitted).[54]

And ***fourth***, the government's invocation of the ratification canon in any event "cannot overcome the plain text" of the statute. *U.S. Ass'n of Reptile Keepers, Inc. v. Zinke*, 852 F.3d

[54] This is particularly the case given the fact that in December 2016—after the Departments issued the 2016 rule limiting STLDI to no more than three months—Congress further amended Section 300gg-91, without addressing the STLDI definition or disturbing the specific provision that defines the term "individual health insurance coverage." 21st Century Cures Act, Pub. L. No. 114-255, div. C, tit. 18, § 18001(c)(1), 130 Stat. 1033, 1344 (2016). Under the logic of the government's own ratification argument, then, it would be at least as accurate, if not more so, to claim that Congress ratified the three-month limit on short-term plans.

1131, 1141-42 (D.C. Cir. 2017). "Where the law is plain, subsequent reenactment does not constitute an adoption of a previous administrative construction." *Demarest v. Manspeaker*, 498 U.S. 184, 190 (1991); *accord, Brown v. Gardner*, 513 U.S. at 121. As discussed above, the meaning of "short-term limited duration insurance" as used in the ACA is plain—and confirms that STLDI does not mean a renewable plan with an initial term of 364 days.

C. Interpreting "Limited Duration" To Encompass Plans That Can Be Renewed For A Total Of 36 Months Is Contrary To Law.

The Department's interpretation of "limited duration" to permit insurance plan renewals of up to three years—with the possibility that, at the time of purchase, these contracts could be stacked on end to give them an even longer effective life—is likewise contrary to law. The plain meaning of the statutory text is that short-term limited duration insurance is a one-time, non-renewable coverage option. "Limited" means "[r]estricted in size, amount, or extent." *Limited*, Oxford English Dictionary, perma.cc/P9ZB-LVJH. But a contract that may be automatically renewed numerous times and replicated so that it effectively lasts indefinitely is, by definition, not restricted to its original term; thus, the STLDI Rule departs from the plain meaning of the statutory language. This conclusion is bolstered by the fact that States that have legislated on the topic of STLDI plans typically refer to such coverage as non-renewable or renewable only for a very short period."[55] In fact, we are not aware of any context in which the term has received an interpretation like that propounded by the Departments here, and the government has not offered one. The point is confirmed by the reality that there is no reason for this sort of long-term renewability unless the plan is designed to serve as a permanent, alternative form of health

[55] *See, e.g.,* 1994 Minn. Laws 556; 1995 N.H. S.B. 30; 1995 Or. S.B. 152; 1995 Ind. S.B. 576; 1995 Mo. S.B. 27; 1995 Tenn. H.B. 1213; 1996 Fla. S.B. 910; 1996 Va. H.B. 1026; 1998 Mich. S.B. 1007; Nev. Admin. Code § 689A.434 (1997); 28 Tex. Admin. Code § 3.3002 (1997); 1998 Colo. H.B. 1053; 2002 Cal. H.B. 424; 2002 Ga. H.B. 1100; 2002 Utah S.B. 122; S.D. Admin. R. 20:06:39:32 (2003); 2009 Wis. S.B. 27; 2013 Kan. H.B. 2107.

insurance; yet no reasonable person would characterize such an open-ended policy as a "limited duration" plan.

A contrary interpretation also would run afoul of Congress's specification that "short term limited duration" insurance be "short term." It does not make sense to believe that Congress would limit the term of individual plans to a period relatively shorter than a year (say, three months), but allow these plans to be renewed repeatedly so that their effective duration is that of full-time, conventional (renewable) annual plans.

And such an interpretation of "limited duration" would be inconsistent with Congress's intent for the same reasons that doom the Departments' interpretation of "short term." Permitting individuals to extend or renew short term limited duration insurance for up to three years further dismantles barriers to healthy individuals leaving the ACA-compliant individual coverage market and purchasing STLDI plans instead. As explained above, this will have the impermissible effect of undermining Congress's policy to create a single risk pool that enables all individuals to obtain to affordable, quality health insurance.

II. THE STLDI RULE IS ARBITRARY AND CAPRICIOUS.

In addition, apart from its departure from the statutory language and policy, the STLDI Rule is arbitrary and capricious. In reviewing the action of the Departments, the Court must engage in a "thorough, probing, in-depth review" (*Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 415 (1971)) to determine whether the agencies have "examine[d] the relevant data and articulate[d] a satisfactory explanation for [their] action . . . ." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Ins. Co.*, 463 U.S. 29, 43 (1983). In conducting this inquiry, the Court must invalidate an agency rule as arbitrary and capricious if "the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence

before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Id.*; *see also Michigan v. EPA*, 135 S. Ct. 2699, 2706 (2015). In addition, where an agency changes its existing policy, it must "show that there are good reasons for the new policy" and that it took into account any "serious reliance interests" the previous policy engendered. *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016).

Here, the Departments' decisionmaking process was riddled with deficiencies, for all of these reasons.

A. The Departments Failed To Provide A Reasoned Explanation For Their Departure From The 2016 Rule.

In promulgating the STLDI Rule, the Departments departed from prior, well-reasoned interpretations of "short-term limited duration insurance"—including over two decades of settled law regarding the meaning of "limited duration" as excluding renewal And they did so without providing the required reasoned explanation or, indeed, any explanation at all.

1. Since the 1990s, the Departments have interpreted "limited duration" plans to be limited to the maximum permissible ***initial*** plan term. *See* 62 Fed. Reg. 16,894 (Apr. 8, 1997). In 2016, the Departments reaffirmed that the maximum period of coverage for "short-term limited duration" insurance may not be enlarged through extensions. They felt the need to do this in light of evidence, detailed in the rulemaking, that "short-term, limited duration [insurance] [was] being sold in situations other than those that the exception from the definition of individual health insurance coverage was initially intended to address." 81 Fed. Reg. 75,316, 75,317 (Oct. 31, 2016); *see id.* at 75,317-18 & n.16. Specifically, "individuals [were] purchasing this coverage as their primary form of health coverage," and "some insurers [were] providing renewals of the coverage that extend the duration beyond 12 months." *Id.* 75,318. This, the Departments explained, resulted in individuals not receiving meaningful health coverage (as mandated by the

ACA) and "adversely impact[ed] the risk pool for Affordable Care Act-compliant coverage" because STLDI policies could discriminate based on health status and target healthier individuals. *Id*. 75,317-18.

In the new STLDI Rule, the Departments do not dispute ***any*** of the facts underlying their previous analysis and conclusion. To the contrary, they ***confirm*** them. *See, e.g.,* 83 Fed. Reg. at 38,231, 38,233-36. The Departments now simply claim that it is desirable to make STLDI "an additional choice for many consumers that exists side-by-side with individual market coverage." *Id*. at 38,218; *see also id.* at 38,222, 38,228, 38,229. But as explained above, making STLDI plans an attractive option for individuals' primary insurance is inconsistent with the ACA and therefore not a permissible basis for justifying the Rule. Moreover, the Departments fail to even acknowledge that they had previously concluded that this outcome was incompatible with the ACA. *Compare* 81 Fed. Reg. at 75,317-18. Such a disregard for that previous conclusion is arbitrary and capricious. *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009).

In defending the Departments' change in position while opposing the preliminary injunction motion, the Departments did not identify any "reasoned explanation . . . for disregarding [these] facts and circumstances that underlay . . . the prior policy"—and they cannot, because they simply ignored the prior regulatory rationale. *Encino Motorcars*, 136 S. Ct. at 2126. Nor did they identify any reasoned explanation for why they suddenly reversed course from their prior conclusion that it would be incompatible with the ACA to treat STLDI plans as an alternative form of primary insurance. *See* 81 Fed. Reg. at 75,317-18. Instead, they contended that the departure was warranted because the 2016 Rule had not succeeded in its goal of "boost[ing] enrollment in individual health insurance coverage." Preliminary Injunction Opp. 39. But that was ***not*** the rationale for the 2016 Rule. Instead, the Departments explained at the time

that the 2016 Rule was intended to address the issue of "short-term, limited-duration insurance being sold as a type of primary coverage" instead of, as intended, "fill[ing] temporary coverage gaps when an individual transitions between sources of primary coverage." 81 Fed. Reg. at 75,318. The Departments regarded closing this loophole as important to effectuate the ACA's intent for two reasons: because STLDI policies had significant limitations and therefore did not provide meaningful coverage; and because STLDI insurers could target healthier individuals, thus "adversely impacting the risk pool for ACA-compliant coverage." *Id.* Meanwhile, guaranteed-issue and special-enrollment-period requirements under the ACA ensured that individuals could purchase individual market coverage if they lost their ACA-compliant insurance, making a three-month STLDI policy adequate for gap-filling purposes. *Id.*

The government's wholesale failure to address the reasons for the Departments' prior interpretation—and instead to address a rationale that did ***not*** underlie that interpretation—is the antithesis of a "reasoned explanation." It accordingly arbitrary and capricious. *Encino Motorcars*, 136 S. Ct. at 2126; *see also Jicarilla Apache Nation v. U.S. Dep't of Interior*, 613 F.3d 1112, 1119-20 (D.C. Cir. 2010).

2. Nor are the other bases cited for the new interpretation of "limited duration" plausible justifications for the new policy. Thus, the Departments attempted to justify their new interpretation by pointing to the fact that Congress did not address STLDI plans in the ACA. 83 Fed. Reg. at 38,220. But that is hardly a basis for disregarding the Departments' own prior contrary conclusion, which of course post-dated enactment of the ACA.

The Departments also noted that transitory COBRA coverage (which requires certain group health plans to extend coverage to individuals who would otherwise lose that coverage) can last up to 36 months in some circumstances. 83 Fed. Reg. at 38,221. But the whole point of

the STLDI Rule is to establish a form of primary coverage that is ***not*** transitory in any meaningful sense. Moreover, COBRA coverage complies with the ACA's requirements and keeps the covered individual in the group coverage risk pool, whereas STLDI plans do not. And although COBRA coverage has long coexisted with STLDI plans, their very different purposes mean that COBRA coverage has always had a far longer duration limit. *See* AARP Preliminary Injunction Br. 19-21. Accordingly, extended COBRA coverage does not offer a suitable model for the STLDI Rule.

B. The STLDI Rule Will Result In Insurance Coverage Gaps For Many Consumers.

The Departments' departure from their 2016 Rule is flawed for an additional reason: It failed to consider the important problem of continuity of care for individuals who lose their coverage mid-year, a problem previously recognized by the Departments themselves and highlighted by numerous commentators. As noted above, the ACA mandates an open enrollment period for individuals who lose minimum essential coverage mid-year. But an STLDI plan qualifies neither as minimum essential coverage nor as a plan in the individual insurance market. 26 C.F.R. § 1.5000A-2(d)(1). As a consequence, an individual who enrolls in ACA-compliant coverage and must change plans will be guaranteed a seamless continuation of coverage; an individual who enrolls in an STLDI plan will not, running the risk of losing his or her eligibility to enroll in full coverage even if he or she later develops an illness or condition that requires costly treatment.

This risk is minimized, however, if STLDI plans are limited to three months or less. Under HHS's regulations, the special enrollment period for the loss of minimum essential coverage lasts for 60 days, and new coverage will begin the month after enrollment. 45 C.F.R. § 155.420(b)(2)(iv), (c)(1). A short term plan of up to three months, then, may cover an

individual's gap during this time between the termination of coverage under one ACA-compliant plan and the beginning of coverage under another.

It was, in part, for this reason that the Departments acted in their 2016 rule to limit STLDI plans to a period of no longer than three months. At that time, the Departments explained that "[s]hort-term, limited duration insurance allows for coverage to fill temporary coverage gaps when an individual transitions between sources of primary coverage." 81 Fed. Reg. at 75,316, 75,318 (Oct. 31, 2016). In contrast, "for longer gaps in coverage, guaranteed availability of coverage and special enrollment period requirements in the individual health insurance market under the Affordable Care Act ensure that individuals can purchase individual market coverage through or outside of the Exchange that is minimum essential coverage and includes the consumer protections of the Affordable Care Act." *Id.*

The new STLDI Rule threatens to upset this balance by permitting "short term" plans to last for longer than three months. Enrollees in these plans will lose their eligibility for enrollment in ACA-compliant plans after the special enrollment period for a gap in comprehensive coverage expires. This runs contrary to Congress's central purpose in providing special enrollment periods for Exchange plans, which, as even HHS itself has recently acknowledged, was to provide a safeguard to preserve the ACA's promise of guaranteed coverage: "In the individual market, … special enrollment periods are intended, in part, to promote continuous enrollment in health coverage during the benefit year by allowing those who were previously enrolled in coverage to obtain new coverage without a lapse or gap in coverage." 82 Fed. Reg. 18,346, 18,355 (Apr. 18, 2017).

A number of commenters noted this concern during the rulemaking proceedings. As one commenter, Community Catalyst, described the issue:

> Moreover, consumers could be left with uncovered bills and/or find themselves "uninsurable." Because insurers can deny a new contract if the enrollee becomes sick or injured during the coverage term, consumers may believe they can extend or renew coverage until rejected by the issuer. If their short-term plan ends before marketplace open enrollment, their loss of coverage would not qualify for a special enrollment period, leaving a consumer to wait until the next annual open enrollment period to select a new plan. This will lead to a gap in coverage for many consumers.

Comment of Community Catalyst, p. 4, https://www.regulations.gov/document?D=CMS-2018-0015-8855. *See also* Comment of Young Invincible, p. 7, https://www.regulations.gov/document?D=CMS-2018-0015-8680; Comment of Centene Corporation, p. 2, https://www.regulations.gov/document?D=CMS-2018-0015-8216; Comment of U.S. PIRG, p. 3, https://www.regulations.gov/document?D=CMS-2018-0015-8932.

In promulgating the STLDI Rule, the Departments acknowledged the submission of these comments (*see* 83 Fed. Reg. at 38,217), but they provided no response beyond that acknowledgement and no indication why they believed it appropriate to encourage a market for STLDI plans when the inevitable result would be that many individuals would be locked out of access to needed comprehensive coverage. This is the hallmark of arbitrary decisionmaking, for two reasons.

First, the Departments failed even to acknowledge, let alone grapple with, this important aspect of their own prior decision making. By failing to "provide an adequate explanation for [their] departure from" their own analysis of the issue in 2016, the Departments fell short of the APA's requirements. *Dillmon v. Nat'l Transp. Safety Bd.*, 588 F.3d 1085, 1089-90 (D.C. Cir. 2009). *See also Fox Television Stations*, 556 U.S. at 515.

Second, the Departments' failure to meaningfully engage with commenters who raised this issue was arbitrary. Although an agency "need not address every comment" made during the notice and comment period, "it must respond in a reasoned manner to those that raise significant

problems." *City of Waukesha v. EPA*, 320 F.3d 228, 257 (D.C. Cir. 2003) (quoting *Reytblatt v. Nuclear Regulatory Comm'n*, 105 F.3d 715, 722 (D.C. Cir. 1997)). Significant comments are those "which, if true, raise points relevant to the agency's decision and which, if adopted, would require a change in an agency's proposed rule." *City of Portland v. EPA,* 507 F.3d 706, 715 (D.C. Cir. 2007). Under this standard, Community Catalyst and others plainly raised significant comments, as they presented powerful grounds for the Departments not to depart from the prior rule limiting short term plans to three months. The Departments, however, simply "refused to engage with" the commenters' concerns. *Delaware Dep't of Nat. Res. & Envtl. Control v. EPA*, 785 F.3d 1, 15 (D.C. Cir. 2015). That failure was arbitrary and capricious.

* * * *

Ultimately, the Departments' fundamental justification for the Rule appears to be that the ACA was badly conceived and that the Departments should be empowered to offer their own alternatives for persons who are dissatisfied with the ACA's requirements. The premise of this contention is wrong; in fact, the ACA has expanded insurance coverage and reduced health care costs—which is why, as the *amicus* briefs filed in this case demonstrate, doctors, patient groups, and consumers almost uniformly support the law and oppose the STLDI Rule. But however that may be, the decision whether the ACA should be replaced or modified is for Congress, not for administrative agencies that are unhappy with the statute's operation. And Congress, although long aware of the complaints now offered by the Departments, repeatedly has refused to repeal the central ACA provisions that are threatened by the STLDI Rule.

For all of these reasons, the STLDI Rule is the very model of a regulation in which agencies have exceeded their legitimate authority: "[T]he [Departments'] rule was an act of amendment, not interpretation. Accordingly, [the Departments] ha[ve] no colorable claim to

Chevron deference." *Central United Life*, 827 F.3d at 74. The Court should hold the Rule to be invalid.

CONCLUSION

The Court should grant Plaintiffs' Motion for Summary Judgment.

Respectfully submitted,

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